KEEGAN ON RHINOPLASTY.[1]

After calling attention to the fact that in India, unlike Europe, rhinoplasty is usually performed to repair the results of mutilation generally in young, healthy and robust patients, whereas in Europe the operation is performed to make good damages due to the ravages of syphilis or lupus, the author remarks that in fifty cases of the former he had employed the Indian operation which had been vastly improved, chiefly by his assistant, Mr. Gunput Singh The main point considered, was to overcome the difficulty of the formation of the columna, and to obviate the continued tendency to contraction in the anterior nares of the newly formed nose, a tendency which continues several months after operation. The shape of the flap, to be employed in a case of lost nose where the entire cartilage, both alae and the columna have disappeared, is quite different from that ordinarily figured in the text-books, as shown in figure 1. The size, or superficial area of the flap, as distinguished from its shape or outline, will depend a good deal upon the make or cast of face of the patient; if his nose was originally a long one, the flap will be proportionately longer, if portions of the alae nasi and columna be left intact, the shape of the

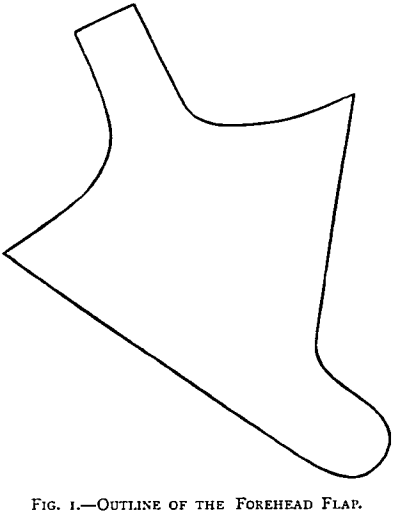

FIG. 1.—OUTLINE OF THE FOREHEAD FLAP.

[1]Surgeon Major D. F. Keegan, M.D. (Indore, India), in The Lancet, Feb. 21, '91.

forehead flap must be modified to suit the requirements of the case. The pedicle of the flap should occupy the internal angle of the eye, care being taken to avoid wounding the angular artery; the flap should be marked out obliquely, not perpendicularly, to a line connecting the eyebrows. In Eastern women, who have low foreheads, it is often necessary to encroach on the scalp to provide for the columna; and although; under such circumstances hair grows upon the newly formed columna, even this is preferable to deforming the mouth by taking the columna from the upper lip, as the hair can be clipped with the scissors.

In operating, the patient having been fully anæsthetized, the cavities on both sides of the septum nasi are plugged with pledgets of cotton-wool to which strings or sutures are attached. Two converging incisions are now carried from two points slightly external to the roots of the alae nasi to two points about three-quarters of an inch apart on the bridge of the nose where a pair of spectacles would rest; these two points on the bridge of the nose are now joined by a longitudinal incision, which is bisected and a perpendicular incision is drawn downward from the point of bisection nearly as far as where the nasal bones join on the cartilage of the nose, following the course of the junction of the nasal bones but not extending as far as their inferior borders. The skin and tissues are now dissected cautiously from off the nasal bones from above downward in two flaps, ABCD and EFGH, as in figure 2.

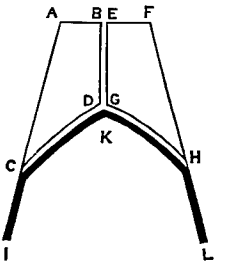

FIG. 2.—PLAN OF LINING FLAPS.
ABEF, Line across bridge of nose.
ABCD, EFGH, Outline of flaps
IKL, Line of margin of mutilated nose.

The inferior borders of the flaps, CD and GH, are not divided and constitute the attachment of the flaps to the structures and tissues which clothe the inferior borders of the nasal bones where they join on to the cartilage of the nose. A piece of brown paper of the shape of the desired forehead flap is now stuck firmly on the forehead in a slanting direction, and a very sharp knife is run around the border of the paper.

The paper is removed, and the flap is quickly raised, embracing all the tissues down to the periosteum, and subjected to as little hand ing as possible. The sides of the gap now left in the forehead are approximated as much as possible by means of horsehair sutures, and it is surprising how small a raw surface is left behind on the forehead, if the approximation of the sides of the gap be judiciously and expeditiously carried out. A nidus or bed for the reception of the columna is now prepared, after the two flaps, ABCD and EFGH, which have already been raised off from the nasal bones, are reflected downward; and, as they overlap in the center two triangular pieces are cut away and placed in the middle of the gap left in the forehead, in order to expedite the process of cicatrization in the frontal scar. The forehead flap is now brought down over the nasal bones and rests inferiorly on the two reflected flaps, ABCD and EFGH, taken off the nasal bones, and the nostrils of the newly formed nose are therefore lined inside with the skin or cuticular sides of the reflected nasal flaps. The free inferior margins of the forehead flap and the nasal flaps are now brought together by horsehair sutures. The columna portion of the forehead flap is now fixed in the bed prepared for it by sutures, and the two original incisions drawn from the root of the alae nasi on either side to the bridge of the nose are now deepened and bevelled off for the reception of the sides or lateral margins of the forehead flaps; these are most accurately attached by means of horsehair sutures to the bed prepared for them. Drainage tubes are inserted in the newly formed nostrils, and the parts properly dressed. After a fortnight the pedicle of the new nose is divided, and in doing so a wedge shaped slice is cut out of the root so that the new nose may not be parrot shaped. The utilization of the skin flaps not only counteracts the tendency to contraction and flattening, but gives strength and support to the nose.

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